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No. 95-1858

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

DENNIS C. VACCO, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, *et al.*,
Respondents.

On Writ of Certiorari To The United States
Court of Appeals For The Second Circuit

BRIEF OF CLARENDON FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Linda L. Bosse
4101 Cathedral Ave, NW
Washington, DC 20016
(202) 362-9331

Ronald D. Maines
(*Counsel of Record*)
Don Loeb
R. Shawn Gunnarson
MAINES & LOEB, PLLC
2300 M Street, NW
Suite 900
Washington, DC 20037

Counsel for *Amicus Curiae*

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INTEREST OF *AMICUS CURIAE*

Pursuant to Rule 37.3 of this Court, Clarendon Foundation respectfully submits this brief *amicus curiae* in support of Petitioners. Written consent to the filing of this brief has been granted by counsel for all parties. The letters of consent have been lodged with the Clerk. Clarendon Foundation is a nonprofit, nonpartisan legal foundation concerned with significant issues related to the Constitution and democratic government. The Foundation participates in various forums in cases where the resolution of constitutional

issues implicates basic rights. The organization is committed to an ongoing review of the tenets of our constitutional government, in the spirit of George Mason's admonition that ". . . no free government, or the blessings of liberty, can be preserved to any people, but . . . by frequent recurrence to fundamental principles." George Mason, THE VIRGINIA DECLARATION OF RIGHTS, *reprinted in* 1 THE PAPERS OF GEORGE MASON, 1725-1792, at 278 (R. Rutland ed. 1970). Because this case raises a question of paramount significance to the public interest, we believe our perspective will complement the brief of Petitioners and assist the Court in the resolution of this matter.

SUMMARY OF ARGUMENT

Decisions regarding the end of life present some of the most challenging constitutional and ethical questions that this Court ever addresses. In *Vacco v. Quill*, No. 95-1858, and *Washington v. Glucksberg*, No. 96-110, the Court considers whether a state may ban voluntary assisted suicide for patients suffering from terminal illness. Two constitutional arguments against such a ban are before the Court. One is whether the Fourteenth Amendment, as a matter of substantive due process, includes the right of terminally ill patients to commit suicide (and further, a right of doctors to assist such patients in carrying out their wishes). We take no position on that question. Instead, we direct our analysis to the argument on which the Second Circuit based its holding in *Quill v. Vacco*: that the New York statute banning assisted suicide violates the Fourteenth Amendment's Equal Protection Clause because it "does not treat similarly circumstanced persons alike." *Quill v. Vacco*, 80 F. 3d 716, 729 (2nd Cir. 1996). For several

reasons, we urge the Court to reject this argument and reverse the Second Circuit's holding.

At the outset, it is essential to avoid the temptation to rely on question-begging characterizations of the classes at issue. Instead, we should look directly at the grounds upon which the classification in question might be thought to rest. In the case of the New York statute at issue here, there are a variety of such grounds. The most obvious is the difference between acts and omissions. This approach, however, while it has surface appeal, raises philosophical issues that undermine its value. Other bases for a legislative classification are more compelling. The State has legitimate interests in preventing patients who have been misdiagnosed as terminally ill from suffering a premature death, in preventing fraudulent certification of patients as terminally ill, in avoiding the difficult philosophical questions involved in defining 'terminal illness', and in protecting people from unwanted physical invasions. All of these interests are served by distinguishing the two classes. Thus, on any of these grounds, the New York statute passes muster under the Equal Protection Clause.

ARGUMENT

The Fourteenth Amendment's Equal Protection Clause requires the government to treat similarly situated people equally. *See* 3 RONALD D. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW § 18.2, at 7 (2d ed. 1992). State legislation generally carries a presumption of constitutional validity if the statutory classification is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985). Social welfare legislation, such as New York's

statutory ban on assisted suicide, needs only to survive rational basis scrutiny to withstand a challenge under the Fourteenth Amendment's Equal Protection Clause. *See Bowen v. Owens*, 476 U.S. 340, 345 (1986).

I. THE LOWER COURTS RELIED ON QUESTION-BEGGING CHARACTERIZATIONS OF THE RELEVANT LEGISLATIVE CLASSES

In this case, the classes in question — those who refuse or wish to be withdrawn from medical treatment and those who desire a physician's help in killing themselves — have a significant feature in common. Both involve people who wish to end their lives as a means to ending their suffering.[1] But, just as clearly, there are also notable differences between the two classes. In one case, the goal can be achieved merely by withdrawing or withholding treatment. In the other, more direct measures must be taken to end the patient's life. Given these similarities and differences between the two classes, one must avoid the temptation to adopt question-begging characterizations of them — characterizations that emphasize either the similarities or the differences merely in order to set the stage for a pre-chosen conclusion to be drawn.

For example, those who wish to treat the classes *alike* emphasize the similarities, pointing out that both consist of

[1] It is worth noting, however, that many people refuse treatment even absent a desire to die. For example, some view extraordinary attempts to prolong life as undignified, even though they would prefer, other things being equal, to live longer.

people wishing to "hasten death." Thus, Judge Miner of the Second Circuit asserts:

> [I]t seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to *hasten their deaths* by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to *hasten death* by self-administering prescribed drugs.

Quill v. Vacco, 80 F. 3d 716, 729 (emphasis added). By contrast, the district court uses words like "natural" and "artificial" to emphasize the *differences* between the two classes: "It is hardly unreasonable or irrational for the State to recognize a difference between *allowing nature to take its course*, even in the most severe situations, and *intentionally using an artificial death-producing device*." *Quill v. Koppell*, 870 F. Supp. 78, 84-85 (S.D.N.Y. 1994) (emphasis added). In both cases, the chosen terminology simply masks a predisposition to find similarities or differences between the two classes. The critical question, therefore, is whether the differences between the classes are rationally related to a legitimate state interest.

II. POSSIBLE GROUNDS FOR DISTINGUISHING THE CLASSES AT ISSUE IN THIS CASE

(1) *The Act/Omission Distinction.* On what basis might a state rationally distinguish between those patients

identified as terminally ill, whom the law permits to refuse life-saving medical care, and those who wish assistance in killing themselves? An obvious starting point is the distinction between acts and omissions or, more specifically, between killing and letting die. Attempts to rely on the act/omission distinction in this context raise two separate questions. *(A)* Is it really true that a doctor who, at the patient's request, withdraws treatment (or withholds treatment) is merely committing an omission (and hence "letting die"), while one who prescribes a lethal dose of medication is acting affirmatively (and hence killing)? And, *(B)* if so, is there any rational basis for thinking that a legitimate state purpose could be furthered by drawing a distinction between killing and letting die in circumstances like those presented in this case?

(A) Is This An Act/Omission Case? This question is difficult to answer. Once again, there are both similarities and differences between removing a patient from life support and administering lethal drugs, and interested parties will characterize the conduct as active or passive depending on how they want the argument to turn out. Those wishing to deny the force of the distinction can point to elements of activity in the behavior associated with withholding or terminating treatment. For example, disconnecting a patient from life support systems involves action, and such action might in certain cases be thought more significant than that involved in the writing of a prescription for a lethal dosage of drugs. Judge Miner's opinion highlights this similarity between the two sorts of cases:

> Moreover, the writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician

> than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide.

Quill v. Vacco, 80 F.3d 716, 729. On the other hand, there is much to be said for the common sense view that terminating treatment is merely "leaving a patient alone," while administering a lethal injection is "doing something to the patient." It is thus not surprising that those wishing to rely on the distinction favor this sort of description.

(B) Is The Act/Omission Distinction Morally Relevant? There is certainly a long tradition of support for this distinction in ordinary moral thought.[2] Yet the distinction

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[2] Professor Bonnie Steinbock points to three places in which the moral significance of the distinction appears to be acknowledged:

> [I]t is clearly against the law to kill another person (with certain exceptions, such as self-defense); and with certain exceptions, the law is indifferent to letting die. Secondly, the Sixth Commandment explicitly prohibits killing (or wrongful killing) but is silent about letting die. And while the Hippocratic Oath explicitly enjoins doctors from giving deadly medicine to anyone, it does not provide clear guidance concerning when treatment may be omitted and a patient allowed to die. In these three areas, then—law, religion, and medicine—the moral significance of the killing/letting die distinction seems to be upheld. B STEINBOCK, KILLING AND LETTING DIE (1980) at 2.

has also been the frequent subject of philosophical criticisms. *See, e.g.*, Michael Tooley, "An Irrelevant Consideration: Killing Versus Letting Die," and James Rachels, "Active And Passive Euthanasia," at 56, 63 in B. STEINBOCK, KILLING AND LETTING DIE, *supra*. Typically, the counter-argument is that other factors which commonly correlate with killing or letting die carry all of the moral weight; the bare distinction between killing and letting die is by itself morally insignificant. As Professor Steinbock observes:

> Most philosophers who question the moral significance of the killing/letting die distinction are not denying that often it does make a difference. Rather, they maintain that it is certain features usually connected with, but not essential to the distinction which make the moral difference. One of these features is the *motivation* of the agent. The motivation of a person who kills someone is generally, though not always, more evil than the motivation of a person who merely lets someone die. Another feature is *certainty of the outcome*. A death is usually more certain if one is trying to kill than if one is merely refraining from preventing a death.

Id. at 2. Likewise, it often takes a good deal more effort to save a person's life than it would to refrain from killing him. Thus, it is sometimes argued, we have less responsibility to save lives than we do to avoid killing people, since saving lives asks more of us than refraining from killing. And similarly, it

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is claimed that the difference between good and bad intentions is what, in certain cases at least, makes the moral difference between killing and letting die.

(2) *The Act/Omission Analysis Is Unnecessary To Resolve This Case*. In both cases discussed above it is possible to analytically "bracket" certain factors in order to ask whether there is any difference between "pure" killing and "pure" letting die. This bracketing allows the philosopher to isolate other factors, in particular the distinction between killing and letting die, in order to test for their moral significance *eo ipso*. To bracket the issue of intentions, the philosopher can ask us to consider a hypothetical case in which the intentions are stipulated to be identical. To bracket the question of effort, the philosopher can focus on a hypothetical case involving (nearly) effortless saving.

But a legislature is not in a position to rely on philosophically pure categories or hypothetical cases when it formulates social policy. Instead it must look to the circumstances of the thousands of real people who will actually be affected by its decisions. What it is possible to do in theory may be impossible or extraordinarily costly to do in practice. In theory it may be possible to distinguish "pure" cases of killing from "pure" cases of letting die; in practice the cases are rarely, if ever, so pure. Real people come with real circumstances, which are generally messy by theoretical standards. It is enough, in the context of legislation, if in the real cases likely to fall under the legislation, the two classes are *generally* correlated with morally relevant differences. The classes at issue in this case meet this requirement.

Thus, it is not really essential to decide whether the withdrawal or withholding of treatment constitutes an act or an omission, whether the sort of assisted suicide at issue in this case is more or less active than that withdrawal or withholding, or even whether the act/omission distinction itself is morally significant. We know enough about the two classes to see that there are *often* morally relevant distinctions between them, regardless of how they are characterized. These differences, set forth below, give a rational basis for distinguishing between the two classes, in the furtherance of legitimate state interests.[3]

III. While Refusal Of Treatment Does Not Require That A Patient Be Identified As Terminally Ill, Assisted Suicide Does Require Such A Determination

We are told that both classes involve terminally ill patients. But what we are actually confronted with is not terminally ill patients, but patients *identified* by someone as terminally ill. The distinction is subtle, but is of the highest importance, since the possibility of misidentification has decidedly different impacts on the two classes.

A. The State Has A Legitimate Interest In Protecting Patients Who Have Been Misdiagnosed As Terminally Ill From Premature Death. One example of such a legally

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[3] The Second Circuit opinion argues that many putative distinctions between the classes do not in fact serve any legitimate state interest. But even if this were correct, the fact that certain interests are not served does *not* undermine the claim that other legitimate interests are served by drawing the distinction in question.

relevant differential impact concerns honest mistakes in identifying patients with terminal illness. We are all familiar with stories about people who are told that they have only a short period to live, but who nevertheless fully recover from their illness. In a withholding of treatment case, it would appear, a patient who has been misidentified as terminally ill simply goes on living. By contrast, in an assisted suicide case, a patient who is not terminally ill nevertheless dies. The State has a clear and legitimate interest in preventing such patients from dying.

Is it really true, however, that a patient who has been misidentified as terminally ill goes on living when treatment is withheld? The answer depends on what we mean by 'terminally ill'. On a narrower interpretation, a person is terminally ill only if he has an untreatable, deadly condition. On a broader interpretation, a patient is also terminally ill if he would die if left untreated, but would live if the treatment were provided.

Which interpretation of 'terminally ill' should we accept? On the narrower interpretation, a patient with late-stage pancreatic cancer who is beyond any possibility of benefit from surgery, chemotherapy, or radiation would be considered terminally ill, but a patient with early-stage melanoma whose life could be extended substantially by a simple surgery would not. On the second interpretation, the melanoma patient would be considered terminally ill as well. But so would a patient who, after recovering from throat surgery, requires intravenous feeding and hydration for a week or more, since this patient would die if the treatment were

withheld.[4] And so also would a patient suffering from a serious infection, for which a reliable antibiotic is readily available. Yet calling such patients terminally ill seems clearly to be a mistake. Thus, the narrower interpretation of 'terminal illness' comes closer to matching our intuitions about its meaning and extension.

With this in mind, what can we say about a patient who has been misidentified as terminally ill? Is it true that such a patient "simply goes on living" if treatment is withheld? Consider the following two cases: Case 1 involves a patient whom we mistakenly believe needs treatment (say, surgery) in order to survive. We withhold the treatment, but the patient lives. Had we actively terminated his life (for example, by administering a lethal dose) he would have died. This appears to be the sort of case imagined above, in which the State's interest in preventing unnecessary death is implicated. Had assisted suicide been forbidden but refusal of treatment allowed, the patient would have continued to live.

Note, however, that we would not have thought of this patient as terminally ill in the ordinary sense of the word. He is thought to be terminally ill only in the broader sense that he will die if he does not receive the treatment, but not if he does receive it. Since the claimed right to assisted suicide applies only to patients identified as terminally ill, assisted suicide would be allowed in cases like this only if we were to adopt

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[4] This example assumes, as we have assumed throughout, that "treatment" includes the provision of life-sustaining food and hydration. This assumption seems reasonable, given that the right to refuse treatment includes the right to refuse the forced provision of these (and other) necessities.

the broader, but less plausible, definition of 'terminal illness'. If instead we were to adopt — as we should — the narrower interpretation, assisted suicide would not be an issue in cases like this, since the patient would not be considered terminally ill. And if not, then the case does not support the claimed distinction between refusal of treatment and assisted suicide.

But now consider a second case. Case 2 involves a patient who is misidentified as terminally ill in the narrower, and more plausible, sense that she will die whether or not she receives treatment. Here what happens to the patient will depend on the sort of withdrawal or withholding of treatment we have in mind. If such a patient chooses to starve herself to death, no doubt she can do so, and she can guarantee her death just as surely as she could by taking a lethal dose. But, as noted earlier, death by starvation can be protracted and painful, and many patients will not choose to undergo it even if they have a sincere wish to die. If the patient does not choose to starve herself to death, and if she has been misidentified as terminally ill, then she will live unless she takes active measures to end her own life. A state has a clear and legitimate interest in protecting a patient such as this from suffering a premature death.

B. The State Has A Legitimate Interest In Preventing Fraudulent Certifications Of Terminal Illness. In any event, there are simpler arguments for treating the two classes differently, and any one of them is sufficient to undermine the equal protection argument. A second argument is based on the fact that fraud is more likely to occur in assisted suicide cases than in withholding of treatment cases. Some people wish to extend the right to die beyond the class of terminally ill patients. It is not uncommon to encounter doctor-assisted

suicides involving patients with multiple scleroses, the early stages of Alzheimer's disease, chronic pain, and other maladies not likely to lead to death in the short run. A doctor who wishes to aid such patients can fraudulently certify that the patient is terminally ill and then help him commit suicide. Detecting the subterfuge will be rendered unlikely by the death of the doctor's only witness. But such a doctor cannot end the life of a person who is not terminally ill simply by withholding treatment. The State has a legitimate interest in preventing fraud and may have an interest in preventing persons who are not terminally ill from taking their own lives.

C. The State Has a Legitimate Interest In Avoiding Difficult Questions Involved In Defining Terminal Illness.

A related issue concerns further difficulties in specifying what is meant by 'terminally ill'. It is often said that we are all terminally ill; some of us just have longer to live than others. Although this is hyperbole, it is related to an important point: It is very difficult to specify what is meant by 'terminal illness' in order to draw a line between those who have a right to assisted suicide and those who do not. One area of difficulty concerns the proximity of death. Is a patient with early-stage prostate cancer terminally ill, even though death due to that form of cancer may be very far off, and a high percentage of such patients die of other causes before the cancer advances to the point where it actually leads to death? Another difficulty relates to the probability that death will occur. The judgment that a patient is terminally ill is of necessity a probabilistic one. If patients had a constitutionally-protected right to assisted suicide, a serious issue would arise regarding how certain a doctor must be before he can declare a patient's illness terminal. A state could reasonably choose to avoid these vexing issues by drawing a bright line between the

withholding of treatment and assisted suicide, since in the former cases no determination that a patient is terminally ill needs to be made.

* * *

Before considering another possible distinction between the two classes at issue here, one final point about our analysis thus far is in order. The very complexity of the issue should give the Court pause before deciding this case against New York on equal protection grounds. The equal protection argument raises difficult questions of fact, involving among other things, predictions about the consequences of various suggested policies. How many patients would actually choose to starve themselves to death? Is there a substantial number of patients who would decline to do so but would choose assisted suicide if offered the option? How frequently does accidental misdiagnosis of terminal illness occur? Questions like these are best left to the legislative branch, which has better information-gathering resources than the judiciary, and a greater ability to change its mind if things turn out differently than expected.

IV. While The Refusal Of Treatment Implicates The Right To Be Free From Unwanted Bodily Invasions, Assisted Suicide Does Not Implicate This Right

A final basis for distinguishing assisted suicide from withdrawal of life support cases has been raised by Professor Ronald Dworkin. The State has a special interest in protecting an individual's right to be free from unwanted bodily invasions. But this right is not a right to have one's body treated in whatever way one wishes. It is one thing to say that an

individual has "a right to be left alone." It is quite a different matter to say that an individual has a right to receive a certain sort of treatment merely because he desires it:

> A right to prevent or stop treatment is part of a more general constitutionally protected right not to suffer unwanted invasions of one's body. But that more general right does not include a right that invasions the patient desires, like lethal pills or injections, be provided—otherwise it would include a constitutional right for everyone to take narcotic drugs, for example.

R. Dworkin, N.Y. REV. OF BOOKS (Aug. 1996) at 45-46. Here again, the distinction between the two classes can rationally be thought to further a legitimate state interest. This time the interest lies in protecting people from unwanted physical invasions — an interest not present in assisted suicide cases.

* * *

Of course, the similarities between the two classes are not irrelevant to constitutional analysis simply because they do not support an equal protection argument. Indeed, it might be thought that whatever constitutionally cognizable interest is served by allowing patients to decline treatment, is indeed hard to distinguish from the similar interest of patients seeking active assistance. Both situations implicate significant concerns about autonomy and privacy, and involve matters of fundamental importance to the conduct of people's lives. Thus, it is possible that a constitutional right to assisted suicide could be inferred from the same provisions that support a right to decline treatment. However, we take no

position on such arguments here. Instead, we believe that the Court cannot bypass this difficult issue by relying, as did the Second Circuit, on a shaky equal protection argument. If there is a constitutional right to assisted suicide, that right must be grounded elsewhere.

CONCLUSION

For the foregoing reasons the decision of the Second Circuit should be reversed.

Respectfully submitted,

Linda L. Bosse
4101 Cathedral Ave, NW
Washington, DC 20016
(202) 362-9331

Ronald D. Maines
(*Counsel of Record*)
Don Loeb
R. Shawn Gunnarson
MAINES & LOEB, PLLC
2300 M Street, NW, Suite 900
Washington, DC 20037

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